Glenashton Dental Centre
Family • Cosmetic • Dentistry
Dr. Harbans Singh Bamrah, B.Sc., D.D.S.

Address: 333 Glenashton Dr
Unit 3, Oakville,
ON, L6H 7P6

Phone: 905-842-5500
E-mail: glenashtondental@gmail.com

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Patient Full Name:

Today's Date: Select Date

○ Male ○ Female ○ Married ○ Single ○ Child ○ Other
Specify

Patient Birth Date: Select Date

Person Responsible for account:

Name of Spouse

Names of Children

Phone (Home):

Phone (Work):

Ext

Best time to call:

Mobile

Email

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Address:

Street

Apartment #

City

Province

Postal Code

Health Information

Name of Previous Dentist:

Telephone Number

Date of Last Dental Visit:

Reason for this visit:

Have you ever had any of the following? Please check those that apply:

☐ AIDS / HIV
☐ Anemia
☐ Angina (chest pain)
☐ Anorexia nervosa
☐ Artificial Heart valve
☐ Arthritis/rheumatism
☐ Artificial Joints (hips, knees, prosthetics)
☐ Asthma
☐ Autism
☐ Blood Disease
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Circulation problems
☐ Congenital heart lesions
☐ Cortisone/steroid
☐ Diabetes
☐ Diet pill therapy
☐ Dizziness
☐ Drug/alcohol dependency
☐ Emphysema
☐ Epilepsy (seizures)
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Glandular disorder
☐ Head/neck Injuries
☐ Heart Disease/attack
☐ Heart Murmur
☐ Heart rhythm disorder
☐ Mitral Valve Prolapse
☐ Migraine Headaches
☐ Hepatitis A/B/C
☐ Herpes
☐ High/Low Blood Pressure
☐ Hodgkin's disease
☐ Hyper (hypo) Glycemia
☐ Jaundice
☐ Kidney Disease
☐ Liver disease
☐ Leukemia
☐ Lung disease
☐ Malignant hyperthermia
☐ Mental/nervous disorders
☐ Organ transplant/implant
☐ Psychiatric disorder
☐ Pacemaker
☐ Radiation Treatment
☐ Chemotherapy treatment
☐ Respiratory Problems
☐ Rheumatic/Scarlet fever
☐ Sickle Cell disease
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Ulcers/Tumors
☐ Venereal Disease

FOR WOMEN ONLY:

Are you breast feeding
☐ Yes ☐ No

Are you pregnant:
☐ Yes ☐ No
Due Date:

Adverse effects to any of the following:

☐ Penicillin
☐ Sulfonamide
☐ Aspirin
☐ Barbiturates
☐ Codeine
☐ Darvon
☐ Local Anaesthetic
☐ None
☐ Other

Allergies (hay fever, latex, etc)

Allergies (hay fever, latex, etc.)

Please list your Medications:

Do you have bad breath or a bad taste in your mouth? ○ No ○ Yes

Do your jaws crack, pop, or grate when you open widely? ○ No ○ Yes

Have you ever had any complications following dental treatment? ○ No ○ Yes

please explain:

Have been to a hospital or needed emergency care during the past two years? ○ No ○ Yes

please explain:

Are you now under the care of a physician? ○ No ○ Yes

please explain:

Name of Physician:

Phone

Do you have any health problems that need further clarification?

Do you smoke? How much per day?

Is there anything else you would like to add to help us make your visits more comfortable?

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient (Name)

☐ Medical Walk in

☐ Yellow Pages

☐ Newsletter

Website Website

☐ Live near by

☐ Road Sign

☐ Newspaper

☐ Pharmacy

☐ Other

Special Concerns:

Are you nervous about dental treatment?	No
Would you like more information on teeth whitening?	No
Would you like more information on braces?	No
Are you aware of night time tooth grinding?	No
Are you satisfied with your teeth?	No
	Specify
Do you require a sports mouth guard?	No

Insurance Holder's Information

PRIMARY INSURANCE PLANS		SECONDARY INSURANCE PLANS	
Name of Insured:		Name of Insured:	
Is insured a patient?	No	Is insured a patient?	No
Insured's Birth Date:	Date	Insured's Birth Date:	2016-04-11
ID/Cert #:		ID:	
Group/Plan/Policy #:		Group#:	
Insurance Company Name:		Insurance Company Name:	
Insured's Employer Name:		Insured's Employer Name:	
Patient's relationship to insured:	◉ Self ○ Spouse ○ Child ○ Other Specify	Patient's relationship to insured:	◉ Self ○ Spouse ○ Child ○ Other Specify

Financial Polices

Your insurance benefits are between you, your employer and your insurance company. Any benefit difference (deductible, fee guide, ineligible service or co-payment) is your responsibility.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

All estimates for approximate.

I have read the above conditions of treatment and payment and agree to their content.

Privacy act:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. I understand that Glenashton Dental Office has a privacy act & will take the steps to protect my information. I know that your office has a Privacy Code, and I can ask to see the code at any time. I agree that Dr. Harbans Singh Bamrah/ Glenashton Dental Centre can collect, use and disclose personal information about myself as set out in the privacy act.

General Release

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my treatment or dental diagnostic procedures. I authorize release, to my insuring company plan administrator and CDA, the information contained in claims submitted electronically.

Relationship to	
Patient:	
Date:	*Select Date*
Printed Name of patient, parent, guardian, or guarantor of payments	